Department of Labor Claim Regulations 101

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Western Claim Conference

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Agenda

- Purpose
- Timeline
- Scope
- Initial Determinations
- Appeals
- Concurrent Care Decisions
- Questions

Purpose

- Ensure timely Benefit Determinations
- Improve Access to Information Used to Make Determinations
- Full and Fair Review of Denied Claims

Timeline

- ERISA Passed in 1974
  - Section 503 – One Sentence
- Regulations Issued in 1977
  - Ignored Managed Care
- Proposed Regulations in 1998
  - Presumed Managed Care
  - Required Some Responses in 24 Hours
- Final Regulations in 2000
  - Somewhat More Reasonable

Final Claim Regulations

- DOL Issued Final Rule November 21, 2000
- Articulate Obligation of Claim Payers to Establish and Maintain Reasonable Claim Procedures
- Minimum Requirements

Regulations Apply to:

- Plans
- Plan Sponsors
- Carriers
- HMOs
- TPAs

Urgent Claims – Initial Determination

- 72 Hours
- Missing Information
  - Must Request within 24 Hours
  - Claimant Has at Least 48 Hours to Respond
  - Decision within 48 Hours of the Earlier of
    - Receipt of Information
    - End of the Period Afforded to Claimant to Provide Information

Pre-Service Claims – Initial Determination

- 15 Days
- May Extend 15 Days IF
  - Necessary due to Matters Out of the Administrator's Control and
  - Notifies the Claimant Prior to the End of the 15 Days
    - Reasons for Extension
    - Expected Date of Decision

Post-Service Health Claims – Initial Determination

- Other Types of Claims, Old Rule Applies
- 30 Days
- Same 15-Day Extension Possible

Disability Claims – Initial Determination

- 45 Days
- Two Extensions of 30 Days Possible

Appeals

"In general. . . Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination."

Appeals

- 180 Days to Appeal
- Medical Issues Reviewed by Health Care Professional
- Identify Experts Consulted
- Reviewer Did Not Make Initial Determination or Be Subordinate to the Initial Decision Maker
- Expedited Review for Urgent Care

Appeals

- Urgent Care claims – 72 Hours
- Pre-Service Claims – 30 Days
- Post-Service Claims – 60 Days
- Disability – 45 Days + 45 with Multi-Employer Rule

Appeals – Other Considerations

- No More than Two Levels of Appeal
- Mandatory Arbitration OK
- Cannot Charge Fees
- Procedures to Ensure Consistent Decisions
- Access to All Documents, guidelines, Protocols and Rules

Concurrent Care Decisions

- Reduction or Termination of Initially Approved Duration
  - Adequate Advance Notification
- Request for Extension of Treatment
  - Within 24 Hours Provided Requested at Least 24 Hours Before End of Approved Course of Treatment

Resources

- Copy of Federal Register
  - http://www.dol.gov/ebsa/regs/fedreg/final/2000029766.pdf
- Questions & Answers
  - http://www.dol.gov/ebsa/pdf/CAGHDP.pdf

Questions

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